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**ASSESSMENT OF THE HEALTH CARE  
FINANCING AND BUDGETING SYSTEM  
IN THE SOUTHERN NATIONS,  
NATIONALITIES, AND PEOPLES' REGION**

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## ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival Project
CHW	Community Health Worker
EC	Ethiopian Calendar
ERRP	Emergency Relief and Rehabilitation Programme
ESHE	Essential Services for Health in Ethiopia
ETB	Ethiopian Birr (\$US1 = ETB 6.63 as of April 1, 1997)
FY	Fiscal Year
GDP	Gross Domestic Product
GoE	Government of Ethiopia
HC	Health Center
HCFS	Health Care Financing
HCFS	Health Care Financing Strategy
IDA	International Development Association (World Bank)
MEDAC	Ministry of Development and Cooperation
MoF	Ministry of Finance
MoH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental Organization
ODA	Office of Development Assistance (U.K.)
PHC	Primary Health Care
PHN	Population, Health, and Nutrition (Officer)
PHRD	Policy and Human Resource Development Project
RFB	Regional Finance Bureau
RHB	Regional Health Bureau
RPB	Regional Planning Bureau
SIP	Sector Investment Programme
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SSA	Sub-Saharan Africa
USAID	United States Agency for International Development
WIBS	Woreda Integrated Basic Services
ZHD	Zonal Health Department

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## **EXECUTIVE SUMMARY**

### **Planning and Budgeting**

The planning and budgeting processes are not working well at present. Part of the reason is that these are new systems that are not yet uniformly implemented, and that there is insufficient trained manpower in position to make the rather complex system work effectively. However, there appear to be two related overriding factors that result in ineffective budgeting, and not incidentally, in many of the inefficiencies seen in the health sector. The main issues are an overall, gross insufficiency of recurrent budget, and a lack of control over capital investment levels at the region and to some extent, priorities.

While it cannot be easily proved, field discussions left the impression that since the actual recurrent budgets were always much less than that actually needed, there was little point in going through the exercise of making accurate forecasts of actual requirements. Therefore, there is little relation between the budget request and service utilization data or even catchment areas.

Allocative inefficiencies resulting from low health worker salaries (and low administrative/planner salaries as well), insufficient drug budgets, and meagre fuel allowances are due mainly to an overall shortage of funds. On the other hand, capital investment has often been overbudgeted in the past, with significant amounts being returned to the Ministry of Finance. In the past this has been due to a lack of absorptive capacity, specifically in construction, that is said to have been alleviated to some degree. In a broad sense, the planning function is decentralized, but the budget process is still somewhat centralized. Another constraint is that the norms set for health facilities do not allow modification to suit local conditions. The most feasible solution to these problems, namely the shifting of some of the capital budget to the recurrent budget, is virtually impossible under the current structure and rules. This is a structural problem that is not unique to the health sector, and will most likely be discussed in detail in the Civil Service Reform Project report on planning and budgeting for the social sector.

### **Health Financing Issues**

The impending approval of the new health care financing strategy (HCFS) for Ethiopia provides an important opportunity to review and refine the strategy and to carry out tests of some of the theoretical assumptions underlying the strategy. The BASICS health care financing advisor can assist in all these activities.

Given the poverty of the rural population, it is essential to assess the true ability of people to pay. This may require development of a rapid-appraisal methodology for assessing incomes in rural areas and associating ability to pay with availability of different providers on a local basis.

Once the HCF secretariat has a clearer picture of the population's ability to pay, various alternative pricing schemes should be evaluated for their revenue-producing potential and effect on equity. Alternative exemption and waiver policies also need to be investigated in detail. Pilot

testing is appropriate at this level of investigation. Other revenue sources should be tested and an inventory made of the various methods that are used throughout the country, especially in NGO facilities. The entire realm of cost recovery for drugs should be studied; specifically the various schemes in operation at present should be compared and their relation to other user fee approaches evaluated.

Finally, a study needs to be made of the role of the private sector in the future health system, taking into account the effects of competition in the urban population centers.

## **I. PURPOSE OF VISIT**

This consultancy had two major objectives: to assess the planning and budgeting processes in use in Ethiopia, especially in the SNNPR, with regard to how they affect the financing of the health sector; and to assess how the BASICS/ESHE project can contribute to health financing initiatives in the southern region and at the national level.

## **II. BACKGROUND**

The relevant background to this visit is that—

- decentralization of the health provision and financing functions of the MoH has been largely accomplished in the past few years, but the central government Ministry of Finance remains the major source of funds for all sectors, including health.
- a health financing strategy has been formulated and submitted for approval which if implemented fully would mobilize a larger share of private resources and allow them to be used locally and allocated in ways that would result in greater efficiency in the provision of health services. User fees have been a part of health financing in Ethiopia for a long time, but until several recent pilot programs, all revenues were returned to the Ministry of Finance.
- a massive new sector investment program for the social sector has been proposed by the prime minister's office with IDA coordination, and it has already received significant donor commitments. There is concern that the size of this program (nearly ETB 0.5 billion) will introduce serious distortions into the health sector and overload its management capacity. This SIP will include incremental recurrent costs for the five years of the capital investment program, but assumptions of the GoE's ability to sustain the increased recurrent burden are based on an extremely optimistic macroeconomic scenario.
- In addition, the externally funded emergency program under which a nearly adequate level of drugs has been supplied to the country for several years is ending this year, and a new National Essential Drugs Programme has been prepared to replace it. The SIP will cover the development part of this new program, but the financial burden of drug supply to the health sector will be placed fully on the health budget in coming years.

With respect to the BASICS/ESHE project, several prior consultancies have assisted the GoE in developing the health financing strategy. The project has had ongoing field activities in strengthening child survival in the SNNPR for nearly a year. One of the functions of the resident health planner is to help the regional health bureau improve the planning and budgeting processes in use there to help achieve a more efficient use of resources. The project has more

recently established a presence in Addis Ababa, one purpose of which is to support the activities of a long-term advisor in a health financing secretariat to be established soon in the MoH.

### **III. TRIP ACTIVITIES**

The first four days of the visit were spent in Addis Ababa reviewing the many recent reports and other documents relevant to the assignment and meeting with MoH and BASICS/ESHE staff. Several of the following days were spent in the SNNPR together with a team from the MoF and MEDAC from a USAID-funded civil service project which was studying the planning and budgeting processes in the health and education sectors. Meetings were held with local officials at regional, zonal, and woreda levels. Some additional days in the SNNPR were spent visiting health facilities to study various approaches at cost recovery and community participation.

### **IV. RESULTS AND CONCLUSIONS**

#### **A. Planning and Budgeting**

The planning and budgeting process was studied at the central MoH level and at the SNNPR regional level, followed by discussions at the zonal and woreda levels and a wrap-up session at the regional council. In the SNNPR, these discussions took place at both the planning offices and the health bureaus. It was sometimes difficult to obtain agreement about the processes, but this can be accounted for by the fact that the system is still in transition and everyone involved is still learning how it should work. However, there is still much need for better coordination and communication in this area. Specifically, the recurrent and capital budgets are the responsibilities of the finance and planning wings of local government respectively, which collaborate only at a late stage of budget preparation.

#### **1. *Zonal and woreda levels***

Capital development projects are proposed by woreda councils, and the zonal planning department assembles and prioritizes these on the basis of estimated ("controlling") budget ceilings. Projects are costed on the basis of standard costs of new facilities, and operating budgets for new facilities are similarly based on standards prepared by the MoH which were found in many zonal and woreda offices. They receive their actual sector budget ceiling around January and process the budget by passing their aggregated plan and request to the regional planning bureau. The capital budget ceiling is received from the region and allocated among the different sectors at the zonal level on the basis of past performance, urgency, the previous budget, absorptive capacity, and sectoral priority. (For example, this year because of increased demand for new projects in Gedeo Zone, some proposed projects had to be excluded in the current budget year.) Zonal health departments prepare their development plans annually, based on a five-year zonal development plan. After the central subsidy is received, the only role of the zonal health

bureau is to make sure that payments are made to contractors after approval by the zonal finance office.

Recurrent budgets are prepared on the basis of inputs from woredas along sectoral lines. Furthermore, the role of the zonal health department in budgeting is to assess the needs of the woredas in water/sanitation, family health, and health services, and to estimate the manpower and resources needed. The latest assessment was done two years ago and has not been updated. Needs are based on population and existing facilities, and costs of resources are based on standards already set for health centres, health posts, improved springs, etc. A team is responsible for these assessments, which consists of representatives from the zonal health department, zonal finance office, woreda health office, and regional health bureau.

New projects are budgeted according to established standards, so in principle, there should not be any budget shortage once the project is in operation. The "budget proposal" excludes salaries, which are allocated and paid at regional level. The recurrent budget categories are salaries, existing and new; drugs; medical supplies; maintenance; freehold (rent); stationery; per diems; and fuel (includes vehicles, fridges, sterilizers, etc.).

In practice, the recurrent budget as approved is based mainly on the last year's budget plus an increment for expansion. A problem arises when the proposer (or "owner") of a new capital project does not propose an adequate recurrent budget, because the zonal finance office has no mandate or incentive to take a pro-active role in changing the request. There is no forward planning for recurrent costs. All items (especially drugs now that the ERRP is finished) and fuel are considered inadequately funded for efficient program operation. The effects of this were seen in KAT zone, where according to data at the zonal health department in Durame, the nominal recurrent budget increased slightly from 1993 to 1996, but about 40 percent more health facilities in the zone were added during this period.

According to the zonal planning department, disbursement delays are no longer a problem, since they are able to get funds promptly from the region and transfer them to woredas, where they are disbursed to the sectoral responsible departments. Capital budgets are transferred as needed into accounts at the Ethiopian Development Bank. Recurrent budgets are disbursed on a 1/12 basis. There are no significant delays with the government-provided subsidy part of the budget; nevertheless, it was reported that no recurrent budget had yet been provided for a facility completed three years ago. The blame for this was put on the Regional Health Bureau (RHB), which allocates the recurrent budget to the zonal health departments. Once the gross recurrent budget arrives at the Zonal Health Department (ZHD), representatives from the woredas come together to allocate it, on the basis of their previously "estimated" budgets.

Locally generated revenues consist mainly of sales tax on cash crops. In Gedeo Zone (population, 740,000), these totaled ETB 16 million, which when combined with the subsidy of ETB 7 million, results in a zonal budget of ETB 23 million, or ETB 31.1 per capita. Of this, the capital portion of the budget was ETB 9.35 million. They do not know what the contribution of external

donors is: there is no accounting for this at the zonal level, and only the work performed is reported to the Regional Planning Bureau (RPB). These amounts do appear in regional budgets (including the value of resident technical advisors and consultants, according to some sources), but the zonal level only receives material items contributed by donors. .

## **2. *Budget adequacy and allocation at zonal and woreda levels***

In the short time available to gather and process data, it was not possible to conclude anything definite about the adequacy of the health facility recurrent budgets or how allocative efficiency could be improved. However, there was general agreement by health staff and managers that drug and fuel shortages were serious hindrances to providing services, and that low salaries (even though workers received a nominal raise recently) had a demotivating effect and resulted in low productivity. A review of health facility budgets by BASICS in 1995 showed that salaries consumed 54, 44, and 67 percent of recurrent budget for central hospitals, non-central hospitals, and health centers respectively. This is somewhat high compared to other countries in the region and probably reflects overstaffing given the low salary scales. Since total budgets are very low, however, it means that all non-salary items receive very low budgets. At Alaba Health Centre, the annual fuel budget last year was only ETB 2,237, which was supposed to supply three motorcycles, two cars, and refrigerators. Drug budgets were estimated at the KAT zonal health bureau to be insufficient by a factor of at least two, perhaps three.

A useful contribution of the long-term BASICS team would be to estimate the actual requirements of typical health facilities<sup>1</sup>. Drug requirements will be estimated eventually under the new Essential Drugs Programme. Fuel requirements can be calculated routinely from outreach schedules and cold-chain characteristics. Maintenance and repair allowances, which are obviously underfunded in Ethiopia, can also be estimated. This type of study has been done by MSH in The Gambia<sup>2</sup>. In addition, an ODA-funded study of health workers' real salary requirements has been done in Uganda.

## **3. *Regional level***

The basis of planning is the current five-year regional health plan, which expresses the health needs of the region in broad terms and is updated and revised annually on the basis of zonal inputs to become a rolling plan that spans one to three years. Planning inputs are, in principle, based on a prioritization of the needs expressed and transmitted from the zonal level. For the capital budget, projects are prioritized and resources are allocated among zones on the basis of need (i.e., existing resources are compared to basic requirements) and the populations served.

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<sup>1</sup> This type of "gap" study has been proposed as a priority activity in the new health care financing strategy draft proposal.

<sup>2</sup> Cost Analysis of Health Facilities in The Gambia. S. Fabricant and W. Newbrander, MSH/World Bank, 1994. See Appendix A for summary.

The distribution of capital projects within a given zone is decided by the zonal health bureau, assisted by the regional bureau of planning and economic development.

The regional recurrent budgets are the responsibility of the regional finance bureau. Operating under estimates of budget ceilings, woreda health bureaus send proposed budget estimates to the zonal planning bureau, where the different sectors are reviewed separately. These are forwarded to the RFB, where the sector budgets are examined by respective sector experts, and are then readjusted according to the actual sector subsidy that will be received. The actual budget is sent back to the zonal health bureaus where, if necessary, it can be reallocated among the woredas.

The organizational structure of the planning process is that the RPB organizes a team from the various sector offices which visits all the zones, compiles their sectoral requirements, and prioritizes them among zones. This description is somewhat different from the perspective of the RHB, which assembles the capital and recurrent budget requests sent up from zonal level, and then submits them to the regional council's planning bureau. (The regional health bureau is not represented directly at the regional council, but there is a representative from the social sector.) The regional council and finance bureau almost always have to reduce the budget allocations to correspond to the revised ceilings.

Capital budgets come down from the MEDAC to the region already broken down by zone and woreda. Expenditures are monitored by the regional health bureau through quarterly zonal expenditure/activity reports, but the RHB has no authority to reallocate the capital budget or the recurrent budget between zones during the budget year, except by mutual request of all zones concerned and the approval of the regional council. (The RHB believed that capital budget allocations from the central MEDAC could be reallocated among sectors at the regional level, which in later discussions was learned to be untrue.) Within a zone, capital budget can be shifted between sectors by the zonal council. If a zone anticipates a shortage in recurrent budget, it can request an extraordinary supplementary budget from the RHB. Unutilized funds are returned to the MoF.

The SNNPR regional health bureau is aware of, and is trying to deal with, problems with unbalanced capital budgeting and expenditure. They say that planned capital investment can be modified if, for example, trained manpower is unavailable immediately or if a needed building is not completed on schedule. (Hiring new trained professional staff is "not a problem" for the RHB, although there is a constraint in that there is a shortage of local professionals, and there is also a restriction on hiring support staff.) They will shift the capital allocation to make existing facilities functional rather than just building new ones. Undoubtedly this is more of a statement of principle rather than fact: the facts reflect that much unspent capital budget gets returned to the MoF, but they admit that they are learning by experience. For FY89 (EC) for all sectors, the capital budget was ETB 231 million, or 346 million, including external assistance, compared to the recurrent budget of ETB 418 million. This ratio of capital:recurrent was thus 40:60 excluding external assistance, or 45:55 if external donors are included.

For FY89, the SNNPR regional capital budget for health is ETB 67 million versus a recurrent budget of ETB 44 million (38:62). There are 16 health centres under construction, with most expected to be completed on schedule because there are now qualified engineers present in every zone. There was also a certain amount of community participation in health, with one zonal hospital and some health centres reported to have been built under the auspices of the regional development zssociation. These were all done according to the five-year plan.

A work plan for budget development exists, but there is no budget calendar, which is considered to be a key problem. It is likely that budgets are submitted in a timely manner and that the delays in disbursements which are widely complained of are due to other factors, including donor disbursement policies. Donor funds are often considered a "headache," with the IDA's disbursement delays singled out as causing a push at year-end for clinic-construction. Some donor-assisted projects never appear as budget contributions, USAID/BASICS being such an example. The RHB may ask the MoH about donor fund allocations and disbursements, but often the MoH is in the dark as well. Once made a part of the regional capital budget, the region has no control over the allocation and use of donor funds.

#### **4. *Central level***

From the perspective of the central (federal) government, the budget planning and allocation process for both recurrent and capital budgets has been minimized since decentralization. The central MoH now funds only programs and projects that have a national-level interest, such as health training institutions, national referral hospitals, and the remaining vertical programs. It is focussing on capital investment on "priority" infrastructure projects, and also provides an extra allocation to the "forgotten" regions such as Afar and Somali.

The regional administrations receive subsidies from the federal government for their social sector capital and recurrent budgets, which are also funded through locally generated revenues (not including user fees, which are sent to the MoF), and donor funds for regional programs. These amounts are decided centrally by the MEDAC and the MoF respectively. The MoH sets standards for health services which the regional health bureaus are mandated to follow as guidelines, and in principle, all decisions as to allocation of revenues are made regionally. At the regional level, planning for capital investment and for recurrent operational expenditures occur in two different processes, respectively the responsibility of the regional planning bureau and the regional finance bureau.

#### **5. *Summary: planning and budgeting***

The planning and budgeting processes are not working well at present. Part of the reason is that these are new systems that are not yet uniformly implemented and that there is insufficient trained manpower in position to make the rather complex system work effectively. However, there appear to be two related overriding factors that result in ineffective budgeting, and not incidentally, in many of the inefficiencies seen in the health sector. The main issues are an

overall, gross insufficiency of recurrent budget, and a lack of control over capital investment levels at the region and to some extent, priorities.

While it cannot be easily proved, the foregoing discussions left the impression that since the actual recurrent budgets were always much less than that actually needed, there was little point in going through the exercise of making accurate forecasts of actual requirements. Therefore, there is little relation between the budget request and service utilization data or even catchment areas. The allocative inefficiencies resulting from low health worker salaries (and low administrative/planner salaries as well), insufficient drug budgets, and meagre fuel allowances are due mainly to an overall shortage of funds. On the other hand, capital investment has often been overbudgeted in the past, with significant amounts being returned from the MoH and, more recently, from the RHBs, to the MoF. In the past this has been due to a lack of absorptive capacity, specifically in construction, that is said to have been alleviated to some degree. In a broad sense, the planning function is decentralized, but the budget process is still somewhat centralized. Another constraint is that the norms set for health facilities do not allow modification to suit local conditions. The most feasible solution to these problems, namely the shifting of some of the capital budget to the recurrent budget, is virtually impossible under the current structure and rules. This is a structural problem that is not unique to the health sector and will most likely be discussed in detail in the Civil Service Reform Project report on planning and budgeting for the social sector.

## **B. Health Sector Financing Issues**

The positioning of the BASICS/ESHE project at both the center and in the SNNPR affords an excellent opportunity to assist the MoH in implementing the new health care financing strategy (HCFS). The draft HCFS has been carefully thought out and taken as far as it is possible to go without actually testing theoretical concepts. Field testing and implementation will be done through the mandated HCF secretariat of the MoH when it is eventually formed, which would also coordinate studies to support the development of the basic strategy. BASICS/ESHE will provide a long-term health financing advisor and also fund other members of the secretariat. In addition, BASICS/ESHE field activities offer the potential for testing new policies and evaluating alternatives at pilot sites in the SNNPR. The following suggestions are in addition to the priority studies described in the draft HCF strategy document.

### ***1. Practical limits to revenue generation under cost recovery***

Local retention of locally generated revenue and additivity of these revenues to government budgets are a hard-won cornerstone of the new HCFS, but are far from being a complete solution. Perhaps the first study that should be carried out relates to the degree of supplemental financing that can be mobilized under the new strategy. The entire rationale for the new strategy is that the financial resources needed to counter the decline in health services and health status of the population cannot totally come from government expenditures. However, since government will have to remain the main funder of health services for many years to come (even with the massive

new donor-funded expansion of services which will increase the recurrent budget required to operate the expanded health facilities), it is important that policymakers do not get the impression that the new strategy will absolve the government of a need to keep increasing the real level of expenditure on health. To ensure this, there must exist reliable estimates of what can realistically be expected from these new financing initiatives in order to set revenue targets, if for no other reason.

Experience with the current user fee scheme has shown that between 18 percent and 46 percent of total costs are recovered in some government hospitals; some NGO hospitals achieve up to 125 percent of non-salary costs. In the SNNPR, Alaba HC collected fees totaling 44.6 percent of total operating costs, or 223 percent of non-salary expenditures (salaries were 81 percent of total recurrent costs). Yirgalem Hospital recovers about 25 percent of total costs (which include a large external grant), and Bamako Initiative pilots are recovering almost all drug costs at health posts. These results have been cause for hope that this trend can be continued and improved. Yet, these are percentages of very minimal recurrent budget levels. It remains to be seen if user fees can represent an important component of total revenues when budgets increase (hopefully) to more adequate levels.

The new HCFS focuses largely on mobilizing private resources. Whether this is called community participation, cost recovery, prepayment, social insurance, or drug revolving fund, it requires ordinary people (usually the sick or their families) to pay for services that were previously supplied free or nearly so, albeit of low quality. Whether or not this enhances welfare and equity depends on many factors that have been discussed in considerable detail while the strategy was being developed. However, little attention has been paid in the documents reviewed to the uncontrovertible fact that Ethiopia is one of the poorest countries on a poor continent.

Not only has government spending on health as a percentage of total expenditures or GDP been extremely low until recent years (although the current level of under \$1 per capita<sup>3</sup>, far below the average for sub-Saharan Africa (SSA), is not even close to adequate), the level of *private* spending is extremely low, a factor of great relevance. Recent surveys have found that household expenditures on health average around 1 or 2 percent of total expenditures (or income)<sup>4</sup>. Even allowing for likely error, this is extremely low compared to the sub-Saharan Africa average of over 5 percent. At the same time, illness is extremely prevalent, with as many as 40 percent of household members in some rural areas reporting illness in the 14 day recall period.<sup>5</sup>

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<sup>3</sup> Real recurrent and capital expenditure totaled 4.46 birr/capita in 1993/94 according to the PRHD Health Sector Review.

<sup>4</sup> Op.cit.

<sup>5</sup> Based on UNICEF/WIBS baseline surveys.

While the immediate explanation for the low rate of private health expenditure is the low coverage of health services<sup>6</sup>, in other countries with similarly low access, the level of private spending is often much higher. This is because alternatives to "medical" facilities such as traditional healers and drug vendors often are as expensive as government clinics. These alternatives are also widely available to Ethiopians, but are not as much used, as indicated by an extremely high level of non-treatment for illness episodes<sup>7</sup>. In most cases, the reason given for non-treatment has to do with distance and transport costs, or not having money for treatment. Apart from transport costs, treatment costs are often substantial and people often report borrowing heavily or selling important assets.<sup>8</sup> (Official prices for treatment are rather low, but most surveys suggest that actual prices paid often exceed these.) Contrary to some findings, evidence from several poor countries indicates that the poor actually pay a higher percentage of their household income/expenditure on health than wealthier ones<sup>9</sup>, with probable negative effects on their nutritional status. Yet even in the poorest areas there will be people who will have no trouble paying high prices for treatment. In urban areas these people are increasingly utilizing the rapidly growing private provider sector.

Some attempts have been made to assess willingness to pay for health services. The results from this type of prospective questioning are not always reliable because they are fairly hypothetical and do not require the respondent to actually pay anything. The results obtained (BASICS 1996) are reasonable-sounding, but must be confirmed by actual field test comparisons before used to establish fees.

Another complicating factor (but also an opportunity for increasing revenues and equity) is that Ethiopia is far from being geographically and economically homogeneous. Some areas have relatively high cash income levels from coffee and other cash crops; others may have relatively low cash incomes, but high wealth in the form of animals. (This may explain the high rate of fee collection at Alaba HC, which is located in an active market town, even though no revenues are retained at the facility.) These factors need to be taken into account, and the decentralization policy may be extended to allow wealthier areas to collect higher fees. As with most attempts to optimize revenues, it introduces an element of complexity. Another differential approach that may be tested involves increasing the markup on cheap, less essential, non-life-saving drugs such as painkillers and antacids. This has been successfully tried in some countries.

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<sup>6</sup> Estimated at 40 percent access, as defined by being within 10-km. of a health facility.

<sup>7</sup> In the PRHD study, only 10 percent of those reporting illness sought *medical* treatment (PRHD study), while the UNICEF/WIBS baseline studies found that over half of sick children never received any form of treatment. This also corresponds to a low rate of health facility contacts per year - less than 1 per capita, compared to SSA rates of nearly 4.

<sup>8</sup> BASICS Community Demand Study, 1996.

<sup>9</sup> Fabricant S.J., Kamara CW and Mills A. "Why the Poor Pay More: Household Curative Expenditures in Sierra Leone." Submitted to *Social Science and Medicine*, 1997.

The fact of poverty has not been totally ignored. Ethiopia was one of the first SSA countries to have an official user fee and exemption policy, with certain groups exempted from full payment, and local committees (kebele and peasants' associations) responsible for certifying a patient's inability to pay the normal fees. This was seen as the solution to the problem of ensuring financial access by the poor and is still the approach most likely to succeed. However, field interviews suggest that this system has become corrupted or at least degraded to the point that it no longer serves a useful role, with high percentages of patients claiming poverty (about 30–40 percent at Yirgalem), having obtained certificates one way or another. It is also observed that some groups that receive fee waivers are the most capable of paying, such as salaried civil servants and police. It is likely that no exemption system is necessary at the lowest level of PHC, however, because the drugs dispensed there are very inexpensive and probably everyone can raise this level of cash. At the Bamako Initiative pilot at Angacha Woreda, everyone is required to pay the full cost of drugs. Much of the burden of disease can be treated with affordable medicines; course of treatment for adult malaria costs ETB 2.00, for example.

Mobilization of private resources in an equitable manner, therefore, depends on setting prices at a level that most people can afford and ensuring that those who truly cannot pay are exempted, that waivers are *not* given to groups or classes of patients who can afford to pay, and that the average amount paid by those who can afford it is as high as possible. Previous BASICS studies have found evidence that official fees are not adhered to, with rather large differences in amounts paid by patients at different health facilities at the same level. When this was found in other countries (Sierra Leone and Uganda), it was found that health workers were taking unofficial payment for services to compensate for their low salaries, with the amount charged roughly corresponding to local ability to pay. The reasons for this finding in Ethiopia should also be studied. Fortunately the new HCFS allows for cross-subsidization, introducing possibilities for more complex price schedules, including sliding scales, at least at the higher-level facilities, so it may be possible to turn a *de facto* system of cross-subsidization into an official one, dependent, of course, on finding a solution to the problem of low health worker salaries. This revenue-side study is a complement to the resource "gap" studies proposed in the draft health care financing strategy which are intended to estimate the resources required to provide reasonable quality primary/preventive and curative services.

An agenda for BASICS work in this area would include policy-level discussions at the HCF secretariat to further clarify issues such as cross-subsidization and geographical variations in pricing. Field piloting of different approaches to poverty certification is an essential requirement, perhaps supported by local income studies and development of a reliable "rapid appraisal" methodology for doing this. The latter method would probably involve the amount of land farmed and assets owned by a household, which would have to be correlated with cash availability. Offering the option of payment in kind (food or other produce) has also been suggested in other countries, but no tests have been made, at least in Ethiopia. This would seem appropriate, especially since community participation in health is now officially encouraged, and could be especially useful at the health post/CHW level.

The fact that some health facilities succeed in collecting very significant amounts of revenue while not being allowed to retain any locally is highly encouraging, even if it is somewhat at odds with the 'received wisdom' of health economists. Whether local retention can actually improve revenue collection should be tested since this will greatly affect the levels of revenues that can be expected. The proposed schedule of fee retention appears to be based on what has been tried in Kenya, but should be modified according to the outcome of the resource gap studies, including the actual resource needs of woreda health offices and zonal/regional/central health bureaus.

## **2. *Roles for the private sector and insurance***

The potential for prepayment schemes for such well-defined groups as coffee-growing cooperatives should also be studied. These groups would be the most likely in rural areas to have access to cash at certain times, but it is not clear that they would be willing to pay significantly high premiums for health coverage when fee-for-service would cost them little relative to their incomes. It has been suggested (by Yirgalem Hospital management) that certain "amenity" or first-class rooms be created to serve such insured patients. A variation on this idea would include less well-off ordinary workers on coffee plantations as well, with a sliding scale for the same or slightly different benefits. This can be modeled and piloted if found to be a useful approach, which would have the advantage of increasing revenues under a purely fee-for-service system as well.

The existence of people who can afford to pay more is a matter of importance to the HCFS in urban areas, as well. The policy 'line' is that the private sector should be encouraged because certain services (most importantly, general curative care) should not be provided by government for reasons of allocative efficiency. At least one negative effect of the rapid growth of the private sector is seen in Awassa Town: scarce trained medical personnel are being attracted away from government facilities by higher salaries. Another difficulty with this policy is that when the wealthiest people receive care outside the government sector, the potential for cross-subsidization of the poor by the rich is reduced.

One element of the new HCFS is enhanced participation of NGOs in the health sector. NGO hospitals have historically delivered an important proportion of curative care in rural Ethiopia, and some are trying to extend this to preventive/promotive care as well. Existing policies should be reviewed by the HCF secretariat to learn how any statutory constraints to this expansion can be removed. It is usually true in SSA that NGO hospitals provide better quality care than government hospitals. This is generally attributed to more adequate budgets and more motivated personnel. The first reason given is as often as not incorrect: many survive on as limited funding as government hospitals, but make much better use of limited resources.<sup>10</sup> Rather than ignoring these models (or worse, closing them down), they should be studied to learn how some of these qualities can be replicated in government facilities. Yirgalem Hospital, for example, has

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<sup>10</sup> See Appendix B for comparison of mission and government hospitals in rural Sierra Leone.

instituted a policy of overtime pay incentives for its employees, who receive normal government scale base salaries.

The role of the private sector in drug supply and distribution is rarely discussed. This seems like a missed opportunity: government is hard-pressed to supply adequate amounts of essential drugs, but given the fact that drug vendors are more widespread than health facilities, and indeed are the only health provider in many rural areas and are well utilized by the population, why has more consideration not been given to enhancing their role as primary health providers? The main rationale for government drug supply for outpatient treatment seems to be a concern for maintaining low drug prices. So far this has proved to be possible at health centers and in pilots such as the Bamako Initiative, but even here the full cost of transport is not included. When all inventory, transport, loss, and management costs are taken into consideration, a typical rural drug revolving fund needs to have a markup of between 70 and 200 percent<sup>11</sup>, considerably more than the legal 15–25 percent markup in the retail drug distribution chain in Ethiopia. The comparison would only be fair if this markup were more closely regulated, as well as the range of drugs on sale by rural drug vendors. Traditional medicines have also been little studied, and the potential for local products substituting for commercial antimalarials, antihelminthics, etc., should be studied. (It is generally believed that most patients try these first before seeking medical treatment.)

Another yet untapped source of increased revenue is automobile insurance coverage for victims of road traffic accidents. These cases account for some 30–40 percent of all acute cases seen at Yirgalem Hospital, but the average charge and reimbursement is very low. Also, although it is not covered by insurance reimbursement, some countries have instituted a policy of high charges for treating people who have been injured in brawls.

To make cost recovery with local retention work, it is also necessary to have effective financial management systems in place. These functions include collecting and accounting for revenue, patient flow and education, and monitoring. Although it is not essential that a national uniform system be established, there should be uniformity at the regional level. A comparative study should be carried out of existing systems.

### **3. *Efficiency-enhancing policies***

The new HCF strategy wisely emphasizes improving efficiency by improving the way resources are allocated, improved management of resources at health facilities, and improving therapeutic effectiveness through rational use of drugs.

The allocative issues were discussed briefly in the preceding section. It is entirely likely that the relatively small increases in facility revenue which will become available through the new user fee program can contribute to alleviating shortages of fuel and drugs, but the problem of

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<sup>11</sup> The literature on this topic is extensive.

insufficient salaries is a complex and difficult one that most SSA governments have not addressed. Some of these issues can be usefully studied and translated into operating procedures in the near term. It is assumed that the issues of selection, quantification, and distribution of drugs will be studied under the new Essential Drug Program (EDP), hopefully including an analysis of the potential role of traditional medicine and drug vendors in the reorganized health system. Long-term allocative issues (e.g., primary versus secondary versus tertiary, rural versus urban, preventive versus curative) will have to be resolved at the policy level, and their resolution should be gradual. The BASICS HCF advisor should monitor the status of this issue and encourage dialogue by means of studies and seminars. It would be unwise to make sharp, sudden changes in resource allocation at this level.

Operational efficiency can be improved mainly at the field level. Here BASICS is in an excellent position to pilot management changes in the SNNPR, which can also be evaluated for their economic impact. It would even be possible to prioritize management-improvement efforts, using economic impact as one criterion, along with feasibility, time-frame, etc. BASICS can assist in operational research that could show the extent of savings possible through better drug procurement, distribution and storage, and also through improved therapeutic efficiency through improvement of rational drug use.

With drug requirements taking up to 40 percent of some government health budgets in SSA, drug management is a clear focus area for improving the financing of health services. At this time there have been user fee initiatives that involve fee-for-service as well as strictly drug charges. The relationship, indeed the compatibility, of these two forms of cost recovery should be studied further.

### **C. Summary: Health Financing Issues**

The impending approval of the new health care financing strategy for Ethiopia provides an important opportunity to review and refine the strategy, and to carry out tests of some of the theoretical assumptions underlying the strategy. The BASICS health care financing advisor can assist in all these activities.

Given the poverty of the rural population, it is essential to assess the true ability of people to pay. This may require development of a rapid-appraisal methodology for assessing incomes in rural areas and associating ability to pay with availability of different providers, on a local basis.

Once the HCF secretariat has a clearer picture of the population's ability to pay, various alternative pricing schemes should be evaluated for their revenue-producing potential and effect on equity. Alternative exemption and waiver policies also need to be investigated in detail. Pilot testing is appropriate at this level of investigation. Other revenue sources should be tested, and an inventory made of the various methods that are used throughout the country, especially in NGO facilities. The entire realm of cost recovery for drugs should be studied; specifically, the various

schemes in operation at present should be compared and their relation to other user fee approaches evaluated.

Finally, a study needs to be made of the role of the private sector in the future health system, taking into account the effects of competition in the urban population centers.

## **V. RECOMMENDATIONS FOR FURTHER ASSISTANCE**

### **A. The BASICS Project Should Use Some of Its Resources in the SNNPR in the Area of Planning and Budgeting**

Decentralization, by its nature, has increased the complexity of the planning and budgeting processes in all sectors, including health. Woreda and zonal authorities need strengthened capabilities in this area and the system itself needs some modification, especially to improve coordination between capital and recurrent budgeting. For recurrent budget estimation, little use is made of actual costs or actual requirements because historically, the budget allocation is far below what has been requested for most non-salary items. With the introduction of fee retention at facilities and a new sector investment program, recurrent budgets will be increased, making it more important that allocations be matched to needs.

The BASICS/ESHE project should assist health bureaus in its focus woredas with methodologies (such as that used in The Gambia) to measure unit costs of services and also to rationalize resource allocation based on activity plans, working upward from facility level. This will also serve in large part as the “resource gap” study for the health care financing strategy. The budget submissions should be followed in the coming year up the channel to the zonal and regional levels.

Being essentially a top-down initiative, the impending sector investment programme will require reprogramming of capital investment plans at all levels of the health system. This represents another opportunity for BASICS/ESHE to use its resources to assist planning offices at all levels of the region.

The disconnect between recurrent and capital budgeting, and especially the lack of flexibility in being able to reprogram capital budget to the (usually insufficient) recurrent budget, has come to the attention of the USAID Civil Service Reform project. It is likely that some recommendations to improve these processes will be forthcoming. The BASICS/ESHE project could facilitate pilot testing of new policies and procedures in the SNNPR.

**B. The BASICS Health Care Financing Advisor Should Assist the HCF Secretariat with High Priority Studies**

The health care financing strategy may have underestimated the seriousness of the problem of low ability to pay by the large part of the population that lives in poverty. It is important to carry out studies which will result in a realistic estimate of the degree that user fees can be relied on to increase resources for health services. The HCF advisor should assist the secretariat in the design of simple studies that can be carried out quickly to serve as a baseline for further planning and implementation of the policy. This priority group of studies will include *development of a rapid appraisal methodology for income measurement, assessment of local ability to pay, and calculation of the maximum level of recovered revenue from households.*

The resource gap studies described in the HCF strategy can be carried out in part in the SNNPR, but if the problems of motivation and control of unofficial fee charging are to be addressed, these studies should also include a study of health workers' salary requirements (as has been done in Uganda). In addition, the advisor should assist in studies which will identify the most effective means of generating increased revenues. These may include variations on *differential pricing* (by geographical area, class of service, and type of drug prescribed, as well as level of service). The role and potential policies for *increasing revenues from insurance companies for road traffic accidents and violence victims* should be studied.

The existing cost-recovery schemes in Ethiopia such as the Bamako initiative, existing user fees, and individual NGOs' policies should be compared and evaluated to determine the best approaches, as well as pitfalls to avoid. In particular, the *relationship between revolving drug funds and other user charge schemes* must be resolved.

Efficiency improvement at health facilities will be accomplished in large part through the Essential Drugs Programme. *The use of NGO health facilities as models of efficient operation should be studied, especially in the area of employee motivation. This should include a study of health workers' subsistence needs.*

Another priority is to review the policy of encouraging the private sector providers in health care, in view of potential problems that have been identified. A careful study of the interaction between public and private sectors in urban areas should be made. The potential role of private drug vendors should also be examined.

## VI. FOLLOW-UP ACTION REQUIRED

The BASICS project should—

- *Follow up with the Ministry of Health on issues concerning the establishment of the health financing secretariat, providing assistance as appropriate.*
- *Proceed with the recruitment and hiring of the resident health financing advisor.*
- *Commence with a unit costing exercise in the SNNPR to serve as a basis for planning and improvements in resource allocation.*

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## BIBLIOGRAPHY

- Bhattacharya, K., et al. 1995. Results of the Community Demand Study for the ESHE Project. USAID/BASICS, August.
- Forgy, L. Background Information on Social Services Public Expenditure Review. USAID.
- Government of Ethiopia and Hamle. 1988. 1989 EC Fiscal Year Budget Proclamation (Draft).
- Health Financing Study Team, November 1994. 1995. Health Care Financing in Ethiopia: The Road to Recovery, Annexes 1–12 (draft).
- Kraushaar, D. 1994. BASICS Support to the Ethiopia Health Financing Strategy, November 7–11, 1994. USAID/BASICS.
- Lagerstedt/Planning and Project Department, Ministry of Health. 1997. Draft strategic health development plan 1987–1991 (ec).
- Ministry of Health and consultants. 1993. Masterplan for the Ethiopia national drugs programme 1994–1998.
- Murray, J. and Serge Manoncourt, 1996. *Ethiopia health facility assessment: using local planning to improve the quality of health facilities in the SNNPR*. USAID/BASICS/ESHE, October.
- Postma, S., M. Tecele, and K. Abashe. 1995. Report of a health system baseline survey. USAID/BASICS.
- Access to and supply of health facilities and services. 1996. PRHD.
- Burden of disease. 1996. PRHD.
- Cost and financing of health facilities and services. 1996. PRHD.
- Cost effectiveness and program evaluations of major health interventions. 1996. PRHD.
- Demand and supply of health manpower: alternative scenarios. 1996. PRHD.
- Ethiopia health financing issues paper*. 1993. USAID/E, December.
- Health care financing strategy (draft), including “Revision and Expansion of the User Fee Program.” 1995. Ministry of Health.

## **BIBLIOGRAPHY**

(Continued)

Health sector investment programme for ethiopia. 1996. Prepared for the Consultative Group Meeting of Dec. 10-12, 1996,.

Health sector review: synthesis and summary. 1996. Policy and Human Resource Development Project, World Bank/GoE.

Household demand for health. 1996. PRHD.

Revolving fund experience for community health service in Angacha Wibs woreda. 1996. UNICEF/SFO.

Southern Ethiopian people's regional government health bureau budget: 1986 (EC) allocated and 1987 (EC) requested and allocated (handwritten translation).

A summary of human resource development strategy in the health sector. 1995. Ministry of Health, Ethiopia.

Woreda integrated basic services (WIBS) baseline survey results, Lanfro Woreda. 1995. TGE/UNICEF, May.

Woreda integrated basic services (WIBS) baseline survey results, Angacha Woreda. 1994. TGE/UNICEF, March.

**APPENDIXES**

**APPENDIX A**

Gambia Health Sector Cost Centre Study

## Appendix A

### Gambia Health Sector Cost-Centre Study, May 1994

1. The cost of operating different types of facilities, the first figure being the current expenditures paid by Government, the second being the total true operating cost, (US\$1=10 Dalasi) which includes unfunded costs such as depreciation and maintenance and donor inputs:

a. Referral hospitals

RVH:	D 17,480,070	D 22,833,000
Bansang:	D 5,113,580	D 7,127,000

b. Major Health Centres (mean of 3 sampled)

	D 598,000	D 1,281,000
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c. Minor Health Centres (mean of 5 sampled)

	D 230,000	D 568,000
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d. Dispensaries (mean of 6 sampled)

	D 138,000	D 302,000
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2. Labor costs as a percentage of government-funded operating expenses:

Hospitals:	RVH: 56%	Bansang: 34%
Major health centres:	67%	
Minor health centres:	59%	
Dispensaries:	55%	

3. Fee revenues as a percent of drug and total funded operating costs:

Hospitals:	RVH:	18.0%, 4.8% (1991 report)
	Bansang:	13.7% 5.7%
Major health centres:		83.6%, 17.8%
Minor health centres:		39.7%, 10.0%
Dispensaries:		32.6%, 10.6%
Sibanor NGO:		148%, 41.8%

4. Average cost per outpatient visit:

RVH:	D 79	Bansang:	D 30
Major Health Centres:	D 7.0		
Minor Health Centres:	D 6.5		
Dispensaries:		D 5.6	

4. Average cost per inpatient admission:

RVH:	D 781	Bansang:	D 462
Major Health Centres:	D 340	(wide range depending on utilization)	
Minor Health Centres:	D 326	(wide range)	

**APPENDIX B**

Comparison of Rural Mission Hospitals and Government Hospitals in Sierra Leone

## Appendix B

### Comparison of rural mission hospitals and government hospitals in Sierra Leone

	GOVERNMENT DISTRICT HOSPITALS			AVERAGES	Connaught	MISSION HOSPITALS				AVERAGES
	Port Loko	Bombali	Tonkolili		Hospital	Mabesseneh (1990)	Muslim Agency	Panguma (1990)	Segbwema (1989)	
Nr. beds	116	70	98	95	300	133	120	127	200	145
Nr. admissions/year*	400	800	300	500	3500	5220	5000	3200	3200	4155
Average % bed occupancy		75	30		85	94.2	100			
OPD consultations/year**	2000	15000	2000	6333	26000	71000	60000	54500	28000	53375
lab procedures/year	1400		3600		11000	21058		25000		
Xrays/year	0	0			5300	854		239		
Surgery/year	200	600	200	333	3000	1186	1800	268	850	1026
Staff:										
Doctors/dentists	2	4	5		28	5	4	3	4	4
Trained nursing	5	14	16		141	10		14		
Administrative			3		2	3		2		
Technician, dispenser, etc	3	4	11		27	3		3		
Nurses aides	48	34	47		88	41		53		
Clerks	12	17	5		101	2		3		
Other	32	65	84		112	30		23		
Total	102	138	171	137	499	94	29	101	142	91.5
Averages: consultations/year/staff				61	53					583
operations/year/doctor				83	107					256
admissions/year/staff				3.6	7.0					45.4

\*estimated from occupancy rates since no data available for GHs

\*\*including PHC under auspices of hospital

\*\*\*Connaught is the national government referral hospital

Source: S. Fabricant, Health Care Financing Issues in Sierra Leone. African Development Bank, 1993.

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**APPENDIX C**

Consultant's Scope of Work

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## Appendix C: Consultant's Scope of Work

### Assessment of the Health Care Financing and budgeting system in the SNNPR

As the health care delivery system in Ethiopia has moved to decentralize and to give Regional health departments increasing control over health activities in their own areas, there is increasing emphasis on the effective management of health care resources. There has not yet been a systematic review of the health care financing system in the SNNPR. This activity proposes to review the health care financing system in the SNNPR, to identify strengths and weaknesses within the system and to propose strategies for improving the management of health funds. All activities will be undertaken with key MOH counterparts and the BASICS/ESHE health planner. The following tasks will be undertaken:

1. An assessment of annual health care planning for delivery of primary, secondary and tertiary health care services at the Regional, Zonal and Woreda levels including: sources of data used for health care budgeting (validity and reliability; how data from the sub-regional levels are transmitted; how service utilization data are used for budgeting;
2. An assessment of the annual health care budgeting process including: unit costs used; how essential services, manpower, recurrent and capital costs are determined and budgeted; how budget allocation decisions are made; how the flow of funds between the central level and the region is managed; accounting procedures; proportion of local funds generated by cost-recovery; how locally generated income is handled and dispersed;
3. Identification of the strengths and weaknesses of the health budgeting process with a summary of possible barriers and solutions to improving weak areas;
4. An outline of further interventions for strengthening the budgeting and planning process with an emphasis on approaches which are feasible with available resources. A clear time line for future activities will be included, with specific responsibilities for local staff and outside consultant clearly stated;
5. Considering, 4 and 5 above, an initial outline of how the proposed national health care financing strategy and its secretariate (including its expatriate advisor) may assist in the improvement of health care financing in the SNNPR. The outline may contain some broad area of assistance.

**Outputs:** A summary report which describes each of the activities 1-5 outlined above and includes a time line for follow-up activities.

**Time frame:** 25 March - 13 April, 1997

**Qualifications required:** A health economist with experience in the areas of health planning budgeting and financing in developing countries.